HEALTH CARE REFORM/Appeals-Clinical Trials-POS-Licensing-Care Continuity

SUBJECT: **Patients' Bill of Rights Act . . . S. 1344. Ashcroft amendment No. 1252 to the Wyden amendment No. 1251 to the Daschle substitute amendment No. 1232.**

ACTION: AMENDMENT AGREED TO, 54-46

SYNOPSIS: As introduced, S. 1344, the Patients' Bill of Rights Act, contains the text of S. 6, a health insurance regulation bill proposed by Senator Kennedy and other Democrats. The bill: will regulate the structure and operation of all health insurance products at the Federal level; will impose extensive mandates on consumers, health insurers, and employers; and will create new rights to sue employers and insurers for unlimited compensatory and punitive damages. As estimated by the Congressional Budget Office (CBO), this Democratic plan will cause insurance premiums to rise by an average of 6.1 percent (which will be in addition to any increases from inflation or other causes). The 6.1-percent cost increase, which will total $72 billion over 5 years, will cause approximately 1.8 million Americans to lose their health insurance coverage.

The Daschle substitute amendment would enact some of the provisions of the Patients' Bill of Rights Plus Act (S. 300) as proposed by Republican Members. (Senator Daschle offered the amendment so that Democrats could propose amendments to it). The Republican bill: would enact consumer protections standards for federally regulated health insurance plans; would require all private group health plans to provide a wide range of comparative information about health insurance coverage; would require all private group health plans to have written grievance procedures, internal appeals processes, and independent external appeals processes; would prohibit all private group and individual health plans from denying coverage, adjusting premiums, or adjusting rates based on genetic history or testing; would give self-employed individuals a full tax deduction for their health insurance costs immediately (currently a full deduction is being phased in; the Daschle amendment dropped this reform); and would give every American the option of starting medical savings accounts (MSAs; the Daschle amendment dropped this reform as well). The CBO estimates that the Republican plan would raise premiums an average of .8 percent. However, its net effect would be to increase the total number of insured Americans because it also would give them access to MSAs and would make insurance more affordable

(See other side)

YEAS (54)

Republicans (54 or 98%)		Democrats (0 or 0%)
Abraham	Hutchinson	
Allard	Hutchison	
Ashcroft	Inhofe	
Bennett	Jeffords	
Bond	Kyl	
Brownback	Lott	
Bunning	Lugar	
Burns	Mack	
Campbell	McCain	
Cochran	McConnell	
Collins	Murkowski	
Coverdell	Nickles	
Craig	Roberts	
Crapo	Roth	
DeWine	Santorum	
Domenici	Sessions	
Enzi	Shelby	
Fitzgerald	Smith, Bob (I)	
Frist	Smith, Gordon	
Gorton	Snowe	
Gramm	Specter	
Grams	Stevens	
Grassley	Thomas	
Gregg	Thompson	
Hagel	Thurmond	
Hatch	Voinovich	
Helms	Warner	

NAYS (46)

Republicans (1 or 2%)	Democrats (45 or 100%)	
Chafee	Akaka	Kennedy
	Baucus	Kerrey
	Bayh	Kerry
	Biden	Kohl
	Bingaman	Landrieu
	Boxer	Lautenberg
	Breaux	Leahy
	Bryan	Levin
	Byrd	Lieberman
	Cleland	Lincoln
	Conrad	Mikulski
	Daschle	Moynihan
	Dodd	Murray
	Dorgan	Reed
	Durbin	Reid
	Edwards	Robb
	Feingold	Rockefeller
	Feinstein	Sarbanes
	Graham	Schumer
	Harkin	Torricelli
	Hollings	Wellstone
	Inouye	Wyden
	Johnson	

NOT VOTING (0)

Republicans (0)	Democrats (0)

EXPLANATION OF ABSENCE:
1—Official Business
2—Necessarily Absent
3—Illness
4—Other

SYMBOLS:
AY—Announced Yea
AN—Announced Nay
PY—Paired Yea
PN—Paired Nay

for self-employed Americans.

The Wyden amendment would add provisions on patient-doctor communications ("gag rules"), discrimination by health plans against certain types of health care professions, point-of-service coverage, and the creation of a "Health Insurance Ombudsman."

The Ashcroft amendment would strike the text of the Wyden amendment and would add provisions on external appeals, clinical trials, provider nondiscrimination, point-of-service coverage, and continuity of care. Details are provided below.

- External appeals: new protections would be added to the external appeals process that would be created by the Republican bill (see vote No. 199 for a description of the grievance, internal, and external appeals process that would be created); a short time limit would be added that would force a health maintenance organization (HMO) to provide all documents on a case to an independent external reviewer or be subject to stiff penalties; a patient would have the right to present evidence to the appeal authority; the reviewer would have to be a qualified doctor or health care professional in the same speciality area as the doctor or health care professional who had recommended the disputed treatment; an external reviewer could set a date by which the health plan would have to provide the disputed service, and, if that date were not met, instead of requiring the patient to go to court (which takes an average of more than 4 years) the patient's plan would automatically convert to fee for service, meaning that the patient could get his or her care from any provider and the health plan would have to pay the bill; also, the health plan would automat ically be fined $10,000, payable to the patient.
- Clinical trials: federally regulated group health plans would be required to allow their cancer patients to participate in clinical trials approved and funded by the National Institutes of Health, the Defense Department, or the Department of Veterans Affairs; they would be required to pay for health care given in those trials except for items and services that the sponsors of the trial would be reasonably expected to pay; a rule-making process would be started that would develop by May, 2000, a definition of the "routine patient costs" of clinical trials that health plans would be required to pay; plans could require trial participants to use in-network providers, if available; if in-network providers were not available, participants would not have to pay any more than they would if such providers were available; a study would be required of this mandate to determine the effect, if any, it had on premiums or other patient costs.
- Provider nondiscrimination: federally regulated group health plans would be prohibited from excluding a class of licensed or certified providers (such as optometrists) from providing treatment for covered benefits; a health plan would not be required to accept all willing providers or to accept licensed providers that provided services for benefits that were not covered by the plan.
- Point-of-service coverage: businesses that had more than 50 employees and that provided self-insured health plans to those employees would be required to give their employees the option of receiving services from health care providers of their choice that were outside of their health plan network of providers; businesses could create separate fee structures for out-of-network providers.
- Continuity of care: plans that terminated or did not renew providers in their networks would be required to notify enrollees and allow continued use of those providers (at the same payment and cost-sharing rates) for up to 90 days in general; institutionalized care provided by those providers would also generally have to be continued for up to 90 days; plans would have to permit continued use of those providers through post-partum care for pregnant patients, and without limit for the terminally ill; a study would be required on how the definition of the term "terminally ill" could be improved.

Those favoring the amendment contended:

This omnibus amendment contains five key parts. First, it would improve the external appeals process in several ways. It would guarantee that it moved expeditiously and that any efforts by an HMO to slow matters would just result in the HMO being fined and the patient being given the needed treatment. In the end, if an HMO refused to abide by an adverse decision by an external reviewer, the patient would be allowed to get the needed treatment from any provider and bill the HMO, plus the HMO would pay a mandatory fine of $10,000 to the patient. Second, the amendment would add provisions that would give patients in federally regulated HMOs access to clinical trials on experimental cancer treatments. Two percent of cancer victims are in such trials. The main group of people who do not have access to such trials are in federally regulated insurance plans or in Medicare. This amendment would take care of the problem as it applies to federally regulated insurance plans. It would also require a study to find if passing this requirement would increase costs. The only two studies that have been done of the issue are promising (they show negligible or no increased costs), but they are neither comprehensive nor peer-reviewed. Many Democrats have complained that we have limited this amendment to cancer victims. Oddly, more than half the Democratic caucus, including every Democrat who has objected to this provision, has cosponsored a bill this Congress by Senator Mack on clinical trials that has exactly the same limitation. Therefore, their objection is not credible. We have proposed a limitation and a study because we want to see how the idea works in practice (we are afraid that it may drive up costs and make insurance unaffordable for many Americans). If it proves beneficial, we will enthusiastically expand it. Third, the amendment would prohibit federally regulated plans from discriminating against providers based on their licenses. This provision is especially important for rural Americans. For instance, some plans require eye care to be given by ophthalmologists, but in many rural areas only optometrists are available. Getting to an ophthalmologist may be a several hundred mile trip. The amendment, unlike the underlying Democratic alternative, is carefully crafted to make certain

that plans would not be forced into providing questionable services, such as for "aromatherapy"' (which is licensed in some States). Every health plan, ultimately, is payed for by its participants; most health plan participants would not like to see their premiums rise so that a few plan participants could go to a licensed aromatherapist to smell stuff. The fourth provision would add a point-of-service coverage mandate for federally insured health plans. This provision would prove most helpful for elderly patients and for rural Americans. Elderly patients have often had the same doctor for years and may wish to continue going to that doctor, especially for certain services. If a health plan changes providers, this provision would require them to have an option whereby their patients could stay with their original providers. For rural Americans, this provision would be particularly important because health care providers are often few and far between, which can make it difficult to get to in-network providers. The fifth and final part of this amendment is that it would add a continuity-of-care mandate for federally regulated health plans. Pregnant women and the terminally ill would not be required to change their doctors if their health plans switched providers during the course of their treatment, and everyone would get a 90-day grace period. This mandate would ensure that critically needed care for patients would not be disrupted due to a plan change. We strongly support all 5 parts of this amendment and urge its adoption.

Those opposing the amendment contended:

Every part of this amendment is inadequate or is a weaker version of a Democratic proposal. The provisions on external review sound good, but they still do not fix the underlying problem with the Republican proposal, which is that it would only allow questions of "medical necessity" to be reviewed, and it would let each health plan define "medical necessity." We know our Republican colleagues sharply disagree that their proposal would allow each health plan's definition to be controlling, and we know that they have pointed to specific language stating that it would not be, but we are not convinced because another part of their bill states otherwise. At best, the situation is ambiguous. America's sick people who are being abused by HMOs deserve better from the Senate than the enactment of a great big question mark. The other four provisions of the amendment are equally weak. To start with, they would only apply to federally regulated plans. We think we ought to impose these mandates on State regulated plans as well so they would cover more people. The other problem with these provisions is that they are just not comprehensive enough. F or instance, the provision on clinical trials would only help cancer patients. What about AIDS patients or patients with other diseases? We think everyone should be helped, and the Democratic alternative would give everyone help. This Republican amendment is clearly inadequate. We urge its rejection.